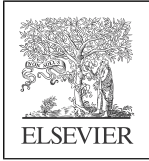




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Application of the model of leadership influence for health professional wellbeing during COVID-19

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ABSTRACT

Background: Nurse burnout is a top patient safety concern. Workplace stress and burnout results in high turnover rates, costs, and lessened productivity and quality care. Although the relationship of burnout to patient outcomes and communication has been proposed, there is little available in terms of a theoretical framework to guide leaders in developing a comprehensive and effective approach to promoting wellbeing and reducing burnout. **Purpose:** This paper demonstrates a theoretical application of the Model of Leadership Influence for Health Professional Wellbeing to support staff wellbeing by developing targeted approaches that address the four dimensions of whole person wellbeing. **Method:** Published literature from the COVID-19 pandemic is used for context to demonstrate the use of the model. **Findings:** The model can be used to facilitate exploration and navigation of the complex issues surrounding burnout and wellbeing. **Discussion:** Leaders may find the model can be a useful tool to promote staff wellbeing.

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The magnitude and impact of nurse burnout is well documented as a top patient safety concern (Bakhamis, Paul, Smith, & Coustasse, 2019; Li, Cheng, & Zhu, 2018; Mattioli, Walters, & Cannon, 2018; Gómez-Urquiza et al., 2017; Jarden, Sandham, Siebert, & Koziol-McLain, 2019; Pradas-Hernández et al., 2018; López-López et al., 2019). Workplace stress and burnout also result in high turnover rates, lessened productivity, and higher costs to the patient and organization; cumulatively, these costs amount to

over \$500 billion to the federal economy (Moss, 2019). The rate of suicide is greater for nurses than the general public (Davidson, Accardi, Sanchez, & Zisook, 2020). Concerned with the implications for patient care, the Joint Commission issued an advisory in 2019 emphasizing the responsibility of healthcare organizations “to support nursing staff and address the causes of burnout” (The Joint Commission, 2019). Perspectives are shifting from the notion that burnout is an individual’s issue or medical condition toward recognition

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that burnout is an occupational phenomenon and that addressing burnout should be an organizational obligation (Moss, 2019; World Health Organization, 2019).

Although models support the relationship of nurse burnout to communication and patient care quality, there has been little available in terms of a theoretical framework to guide leaders in developing comprehensive and effective approaches to promote wellbeing and reduce burnout and tracking the results from different approaches. The Model of Leadership Influence for Health Professional Wellbeing (Bogue & Carter, 2022) offers a theoretical framework for organizational leaders to promote wellbeing and reduce burnout for their employees. The model promotes development and testing of targeted approaches that address one or more of four dimensions of whole person wellbeing. Using COVID-19 literature for context, this paper explores how the model can support leaders in advancing health professional wellbeing (Figure 1).

Background

One barrier to reducing nurse burnout is the absence of an action model for nurse leaders to guide an ongoing, comprehensive, and effective approach to promote wellbeing and reduce burnout for their staff. The Model of Leadership Influence for Health Professional Wellbeing (Bogue & Carter, 2022) was designed to help leaders identify relevant concerns and inputs to burnout, identify appropriate actions, and measure outcomes. The model was developed from theoretical and empirical sources (Bogue & Fisak, 2011;

Gates et al., 2019; Bogue, 2019; Bogue & Downing, 2019) and confirmed in a study of 1,126 nurses at a south-eastern U.S. academic medical center (Bogue & Carter, 2019, 2022).

The Model of Leadership Influence for Health Professional Wellbeing can help leaders identify, test, and evaluate actions that may reduce burnout by generating wellbeing among health professionals (Bogue & Downing, 2019; Hamilton & Bogue, 2012a; Hamilton & Bogue, 2012b; Herring, Forbes-Kaufman, & Bogue, 2016; Bogue, 2019). The model illustrates that stressors exist for everyone in the work environment and in life in general. These stressors are Inputs that influence levels of burnout.

The Process section of this model serves to identify and test the efficacy of solutions for addressing burnout. In the workplace in particular, nurse leaders can identify, promote, develop or implement, and evaluate processes of wellbeing that may mitigate or manage stressors. The designs for these wellbeing processes emerge from individual, group (family, work unit, department, organization) and/or nurse leadership practices that can help manage or mitigate stressors with and for nurses.

Individual and group processes for averting the outcome of burnout can be imagined and designed. And their impacts can be measured, by adopting a whole person perspective organized within four domains of wellbeing that are reflected in the Nurse Wellbeing Self-Assessment (NWSAT): bio-physical (BIO), psycho-emotional (EMO), socio-relational (RELA) and religio-spiritual (SPIR) (Bogue & Carter, 2022). In brief, wellbeing is generated by mindfulness and actions that manage or mitigate stressors, thereby reducing burnout

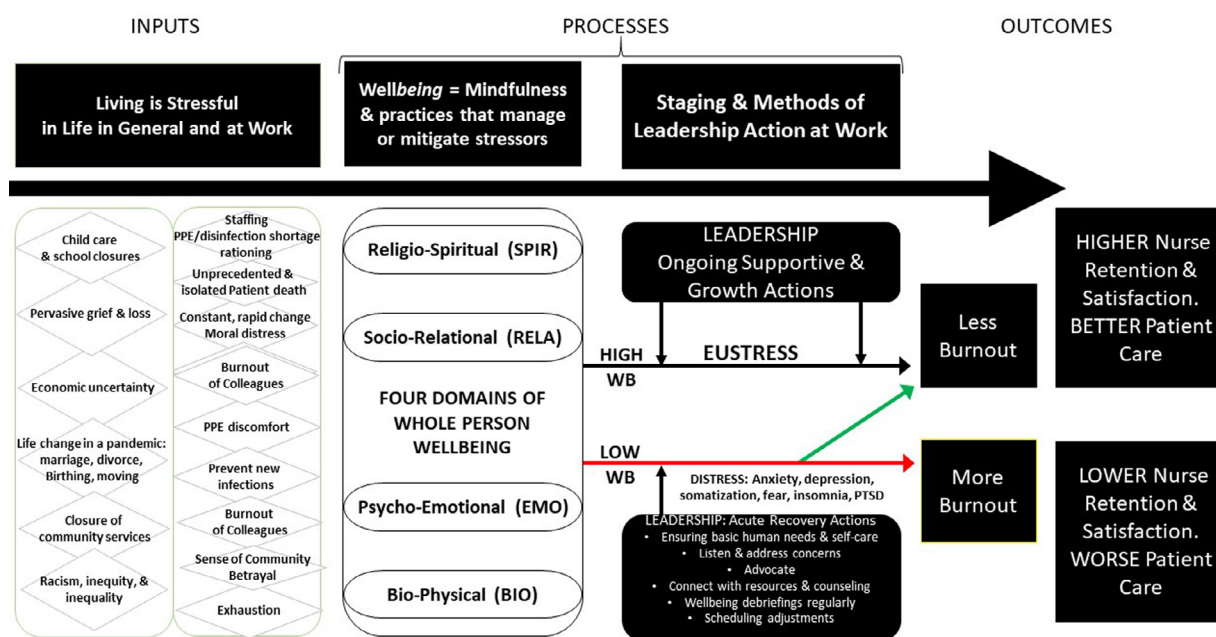


Figure 1 – Model demonstration during COVID 19

outcomes. Wellbeing is an active process with a vast variety of possible approaches.

Nurse leaders can help reduce burnout outcomes by consciously drawing on individual, team, group and organization-wide assets to implement wellbeing processes. Leaders can implement interventions to address one or both of two distinct pathways for managing or mitigating the outcome of burnout: (1) Ongoing Supportive Growth Actions to help sustain eustress among the workforce and (2) Acute Recovery Actions to help restore professionals who are experiencing distress. More detail about the development of the Model of Leadership Influence for Health Professional Wellbeing is described elsewhere (Bogue & Carter, 2022).

To examine the assumptions within the Model of Leadership Influence for Health Professional Wellbeing, we used literature from the first year of the SARS-CoV-2 (COVID-19) pandemic. This paper explores the relevance of the four dimensions of wellbeing and the process and outcomes therein to demonstrate the ability of the model to identify stressors and actions to support wellbeing and counteract burnout.

Application of the Model within the context of SARS-CoV-2

The SARS-CoV-2 (COVID-19) pandemic introduces layers of challenges that today's nurses never experienced before at such complex levels. The Model of Leadership Influence on Health Professional Wellbeing provides a framework for recognizing these challenges and guiding discussions and steps to generate wellbeing, reducing burnout during the COVID-19 pandemic and under more normal circumstances.

Inputs

The pandemic has certainly been stressful in life in general and at work. The personal impact for nurses during the first year of the COVID-19 pandemic was intense, including concern for the safety of those in shared living spaces, school and social event closures, childcare, grief, and loss of family, friends, and colleagues, among many others (Beckman, 2020). While work-related stressors were already significant, COVID-19 augmented those stressors for healthcare workers. Mahgoub and colleagues (Mahgoub et al., 2021) found that 60% of the healthcare professionals in state hospitals in Sudan reported stress, anxiety, and poor work-family balance. These work-related challenges have and may continue to include shortages and rationing of personal protective equipment (PPE) and disinfection supplies, providing care as a faceless clinician with a muffled voice behind a mask, short-staffing, rapidly and constantly changing practices, moral distress, economic uncertainty, patients seeing

their families during their last moments or dying alone, and overwhelming numbers of patients expiring (Beckman, 2020; Clarke, 2020; Maouyo, Noon, Hobilla, Kim, & Roush, 2020).

Grief has been pervasive throughout the pandemic due to deaths of family, friends, and colleagues, often without the comfort of end-of-life gatherings and funerals (Clarke, 2020). The increased volume of patient deaths without the presence of significant others due to visitation restrictions generated stress-related trauma among nurses. In addition, care of the deceased body in a sensitive manner, when morgue resources were overflowing and the patient room was needed for the next seriously ill patient, added to the distress (Maouyo et al., 2020). Providing patient care in PPE introduced personal physical challenges including dermatologic effects, temporary visual impairment, chest discomfort, and breathing difficulties (Maouyo et al., 2020; Zhang et al., 2020). Always at the forefront was the need to prevent new infections (Diez-Sampedro et al., 2020).

While being touted as heroes (Beckman, 2020; Clarke, 2020), some nurses also experienced a sense of betrayal from the community via social and news media who inferred that healthcare workers knew what they had signed up for and should silently do their jobs (Maouyo et al., 2020). Further, many nurses were frustrated by a public who were not wearing masks; this often felt like a losing battle for nurses caring for larger numbers of seriously sick and dying patients than the facility's capacity (Maouyo et al., 2020). As the pandemic unfolded, issues of systemic racism, inequity, and inequality emerged (Odom-Forren, 2020; Williams, 2020).

While nurses typically faced the pandemic with pride and professionalism in meeting the responsibilities of their calling (Zhang et al., 2020), they were physically exhausted and increasingly pressured to "do their part" through mandatory overtime (Schutz & Shattell, 2020). Some nurses felt undervalued and unsupported by their employers (Schutz & Shattell, 2020). They questioned the personal sacrifices they were making and the risk they presented to their families when they were either furloughed or overworked, and worked through various uncertainties, including economic (Beckman, 2020; Clarke, 2020). Nurses experienced profound psychological effects, including anxiety, depression, somatization, fear, insomnia, post-traumatic stress disorder, daily emotional trauma (Zhang et al., 2020), and role frustration (Brockopp, Monroe, Davies, Cawood, & Cantrell, 2021). As nurses separated themselves to protect their families, they experienced isolation and loss of intimacy (Beckman, 2020).

Closures of community services, as well as shortages that emerged while nurses were working, such as grocery availability, childcare services, and fitness and wellness services, added more stressors (Beckman, 2020).

Processes

The middle section of the model illustrates the key role of the leader to examine the four domains of whole person wellbeing to identify actions that can increase the level of wellbeing as individuals as well as the collective staff. The NWSAT is a tool to support and act on this awareness (Bogue & Carter, 2022). With respect to individuals, teams, or units, if indicators reflect staff in a level of eustress, then the leadership role is to maintain wellbeing—and keep burnout under control by providing ongoing supportive and growth actions. When indicators suggest a level of distress, then acute recovery actions are appropriate with the goal of shifting the path from burnout to a higher level of wellbeing. The earlier that distress is identified, the more opportunity to redirect the wellbeing trajectory, thereby more likelihood for impacting communication, patient outcomes, and other potential ultimate outcomes.

The Process section of the model guides the leader to consider the whole person through the SPIR, RELA, EMO, and BIO domains as measured with NWSAT. The development and psychometric examination of these four domains of wellbeing is found in a companion piece in this issue (Bogue & Carter, 2022). Actions that reflect a holistic, adaptable approach to reducing burnout by supporting wellbeing within the four domains are illustrated with examples below.

While often a neglected domain, SPIR is important to address and is deeply meaningful to many individuals. As described in (Bogue & Carter, 2022) SPIR is comprised of two factors: Purpose and Faith. Leaders can partner with chaplains during leader rounds to identify SPIR concerns of staff and, in response, organize SPIR-strengthening events. Examples include compassion toward others, whole person care, animal therapy, wilderness activities, guided mindfulness sessions, and establishing spiritually nourishing spaces for staff, such as chapels and Watson Rooms (Bogue & Carter, 2019, 2022).

RELA is comprised of three factors: Connectedness, Interaction Quality and Work-related Frustrations. Leaders can actively support RELA interventions such as strengthening individuals' sense of belonging, fostering positive relationships, and reducing procedural barriers to quality care, as well as clear communication, equal and inclusive treatment, and not tolerating incivility (Bogue & Carter, 2019; Bogue & Carter, 2022; Sharifi, Asadi-Pooya, & Mousavi-Roknabadi, 2020). Additionally, leaders can ensure that problems faced by the team are reviewed and decompressed through stress and wellbeing debriefings at least every two weeks (Bogue & Carter, 2019).

EMO wellbeing has three factors: Distress, Support and Balance. Leaders can enhance EMO wellbeing through finding ways to reduce extra pressures and providing accessible, timely, and on-site employee assistance programs or counseling. Other EMO promoting steps include routine screenings for stress and anxiety, encouraging web-based programs that

address work-related stress, meaningful acknowledgment for all employees, scheduled debriefings at least every 2 weeks, and supportive actions like Code Lavender (Bogue & Carter, 2019, 2022; Mahgoub et al., 2021).

Finally, the BIO wellbeing scale has three factors: Stress, Lack of Support, and Work-Life Balance. Leaders can improve BIO wellbeing and thereby reduce burnout through staffing, call practices, overtime, shift length, patient loads, and addressing work-life balance. Leaders can place more attention on scheduling that considers the changing demands imposed by school closures, family care needs, and other personal challenges. An important component of the work environment includes addressing cost-containment strategies that jeopardize quality care and optimal patient outcomes by reducing professional nurse labor hours using antiquated staffing models (Avalere Health LLC, 2015).

Other strategies to support BIO wellbeing might include massage, therapeutic touch, aromatherapy, and healthy food options. It is important that all staff, including night and weekend staff, be considered. (Bogue & Carter, 2019, 2022).

The four components of wellbeing (BIO, EMO, RELA, & SPIR) are not isolated and independent. Rather, they reflect a complex and dynamic interplay of aspects of human experience that suggest concrete steps to manage or mitigate stressors by actively improving wellbeing and are most effectively addressed as such.

Managing or mitigating stressors has been even more challenging for nurses during the COVID-19 pandemic. COVID-19 removed many outlets that people, and especially nurses, had developed to support wellbeing. Social distancing was introduced to daily language, with the effect of reduced social connecting, such as hugs and sending flowers (Hayes, 2020). New wellbeing and mindfulness practices to manage or mitigate stressors needed to be cultivated.

As the pandemic continues unfolding, the severity and longevity of stressors on nurses compels nursing leadership to address the lowered wellbeing of nurses and to introduce or support wellbeing practices to shift the distress trajectory toward a higher level of wellbeing and eustress. The importance of leadership visibility, role reconceptualization and transparency has never been greater (Beckman, 2020; Proulx, 2020; Zhang et al., 2020). Leadership support of basic human needs is vital, including supporting staff for self-care, such as capturing brief times of quiet, a space to eat, drink and re-energize (Nalley, 2020; Newby, Mabry, Carlisle, Olson, & Lane, 2020; Zhang et al., 2020). The presence and engagement of senior and executive leadership is important to convey to staff that they are making decisions based on accurate, firsthand knowledge of the reality of the unit (Brockopp et al., 2021). The need for informed leader advocacy on behalf of frontline nurses is crucial, as well as ensuring nurses' voices are heard to address PPE shortages, education needs, and navigating difficult conversations and ethical dilemmas, among other needs (Nalley, 2020).

Support for evidence-based approaches, such as brief mindfulness and cognitive-behavioral therapy-based interventions, visual triggers to promote physical activity, and Code Lavender to sooth the acutely troubled human spirit, can enhance staff wellbeing (Melnyk et al., 2020; Phillips, Androski, & Winks, 2018). Building on a philosophical rationale for a bio-psycho-social-spiritual approach to wellbeing as outlined by Bogue (2019), leaders can ensure that the system's confidential counseling for staff is available and accessible. They can ensure adequate space and time for exercise, rest, and prayer, foster a work environment of collegiality and mutual support, and make food available or provide healthier options. The crucial role of the leader is to identify, navigate, and overcome the organizational barriers and obstacles, unique to every situation, to allow the important work of caring for staff to be possible.

Outcomes

Higher levels of burnout threaten effective communication and patient care (Bodenheimer & Sinsky, 2014; Fitzpatrick, Broome, & Blake, 2019). By actively seeking and implementing ways to improve work-life balance, patients, providers and organizations can reap the benefits (O'Connor, 2020). By encompassing the four domains of whole-person wellbeing, leaders can invoke processes to combat burnout. Whether maintaining eustress or shifting the distress trajectory toward a higher level of wellbeing for staff, burnout is better managed or mitigated, and safer, more effective patient care can also result (Dans & Lundmark, 2019).

Successful processes for increasing wellbeing may consistently lead to less burnout, although more work is needed to identify best practices and their impact on outcomes (de Oliveira, de Alcantara Sousa, Vieira Gadelha, & do Nascimento, 2019). The Model of Leadership Influence on Health Professional Wellbeing can be a useful approach to developing and testing the impact of practices as leadership actively seeks ways to combat burnout.

Conclusion

The SARS-CoV-2 (COVID-19) pandemic has wreaked havoc in the personal and professional lives of many, introducing challenges for leaders to support the wellbeing of staff. Using published literature from the COVID-19 pandemic, this paper demonstrated the ability of the Model of Leadership Influence on Health Professional Wellbeing to frame the complexity of the issues surrounding burnout and wellbeing. This paper examined the use of the Model from a theoretical approach using the literature from a recent event. The next step will be for leaders in their respective settings to examine the Model's use in real-world situations. As the Coronavirus pandemic continues, or other such

challenges emerge, wellbeing needs may also shift and evolve. On an ongoing basis, organization leaders should reassess individual and group needs specific to emerging challenges of caring faced by nurses for patients, nurses themselves and their colleagues during an extended pandemic.

Even prior to the COVID-19 pandemic, Healthcare employees encountered inputs and processes that required action to support wellbeing. Turnover rates and engagement scores are a reflection of how effective these actions may have been. Although COVID-19 took the limelight, these other challenges did not go away, and continue to be opportunities for leaders to provide supportive actions for their staff. More work is needed to examine the effectiveness of the model in a variety of situations.

Using this model, leaders can identify and evaluate the stressors that challenge their staff, individually and collectively. They then can use the domains of whole-person wellbeing to ensure that strategies to promote wellbeing are appropriately targeted and measurable using one or more of the NWSAT scales (BIO, EMO, RELA, SPIR) to confront stressors and to measure the impact. The goal of these strategies is to shift the wellbeing trajectory away from distress toward eustress, or maintain and enhance levels of eustress, with the ultimate aim of reducing burnout. The ultimate goal is to promote the wellbeing for the valuable human resources who provide complex care in this constantly changing healthcare environment.

Authors contributions

Kimberly Ferren Carter: Funding acquisition; project administration; leading on researching and writing the applications of the model during COVID-19, reviewing and editing both full manuscripts. Richard J. Bogue: Methodology; data collection, curation and management; project administration; analyses; modeling; statistical results; writing the introduction, background, methods, and findings sections of the original draft; reviewing and editing both manuscripts; producing visualizations.

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